MFP Assessment

PERSONAL DATA (Resident) Date of Assessment: _____

1. Name:_____Maiden or Other(_____)

2. Phone: (_____) _____-_____ ☐Consumer ☐Other (_____)

3. SSN: _____/_____/_____ Race: _____ 4. Date of Birth _____/_____/_____ Age: ____

5. Gender: ☐Male ☐ Female 6. Marital Status: ☐Single ☐Married ☐ Divorced ☐Widow

7: Citizen: ☐Y ☐ N 8. Spoken Language: ☐English ☐Spanish ☐Other_____
9. Written Language: ☐English ☐Spanish ☐Other_____

10. Income:☐SS ☐SSI ☐SSDI ☐Other ☐Not Sure 11. Eligibility: ☐Medicaid ☐Medicare

12. Primary Diagnosis:_____

13. Other Diagnosis:_____

14. Date of Admission to current Facility: _____ 15. Previous Facility Adm: ☐Y ☐N Date(s):_____

16. Legal Guardian: ☐ Self ☐Parent_____ Other_____
Power of Attorney to: _____ Type of Power of Attorney: _____

17. Do you have Advanced Health Care Directive? ☐Y ☐N **18. MEDICAID RECIPIENT ☐Y ☐N**

19. FAMILY/ FRIENDS/ADVOCATES
Names/Relationship Phone
_____ _____

Address: _____

Name/Relationship Phone
_____ _____

Address_____

20. FACILITY INFORMATION
Name of Facility: _____

Address: _____City:_____ State: __ ZIP: _____County:_____

Contact/Title: _____ Phone: (_____) _____-_____
Fax: (_____) _____-_____
Physician: _____ Phone: (_____) _____-_____

DHS-8503 **(Completed by Ombudsman and DD Specialist Only)**
(11/17/2008)

MFP Assessment

WHAT WAS YOUR REASON FOR ENTERING THE FACILITY?

Check All That Apply.
A ☐ Treatment for Medical condition
B ☐ Health or personal care problems while in community
C ☐ Unable to return home from hospital/rehab facility
D ☐ Difficulty in maintaining community residence

Comments:

EMOTIONAL AND BEHAVIORAL ISSUES

Have You Experienced Any Major Life Changes (Crises) in the Past Year? ☐Yes ☐No

Identify:

MFP Assessment

COMMUNITY BASED SUPPORTS

Please Think of Your Relatives (besides those who live in this house/apartment) **to Whom You Feel Close: Your Children, Brothers, Sisters, Spouse or Other Relatives. What Are Their Names and Their Relationship to You?**

Name	Relationship	Telephone

Do You Have Any Friends or Neighbors Who Would Be Available If You Need Help? ☐Yes ☐No
Identify:

Who Is Your Main Supporter? _____
How is this Person's Health ☐Good ☐Fair ☐Poor

Assessment Completed by Name & Title: _____
Date Completed: _____
Email Address and Contact Number: _____

DHS-8503 **(Completed by Ombudsman and DD Specialist Only)**
(11/17/2008)

MFP Assessment

MEDICAL CONDITION AND PROFESSIONAL CARE NEEDS

1. Primary Medical Diagnosis: _____
2. Cognitive/Behavior: □No Problem *If resident is unable to answer, solicit information from Another source and identify source: _____

☐Memory Loss ☐Behavioral Concerns_____
☐Wandering ☐Depression
☐Anxiety
☐History of Alcohol/Drug abuse(please explain):_____
☐Episodes of abuse:_____
☐Other (please explain)_____

3. Hearing Loss: ☐None ☐Mild ☐Moderate ☐Severe

☐Hearing Aid ☐Sign Language ☐Difficulty Understanding Conversation

4. Speech Impaired: ☐None ☐Mild ☐Moderate ☐Severe

☐Uses communication board ☐Uses electronic communication device

5. Vision: ☐None ☐Mild ☐Moderate ☐Severe ☐ Reading Glasses (Only)

☐Contacts ☐Magnifier ☐Large Print

DHS-8503 **(Completed by DD Specialist and ITM Only)**
(11/17/2008)

MFP Assessment

EMOTIONAL AND BEHAVIORAL ISSUES

DO YOU:

- ☐ Feel Lonely
- ☐ Have Sleep Problems
- ☐ Lose Interest

ARE YOU:

- ☐ Not Eating
- ☐ Worried, Anxious
- ☐ Feeling Depressed

WORKER OBSERVATIONS:

- ☐ Abusive or Assaultive
- ☐ Wandering
- ☐ Unsafe or Unhealthy Hygiene or Habits
- ☐ Threats to Health or Safety
- ☐ Inappropriate Social/Sexual Behaviors
- ☐ Appears Angry
- ☐ Fearful
- ☐ Client Requires Supervision Due to These Behaviors
- ☐ Shaky, Trembling, Crying
- ☐ Depressed Affect
- ☐ Appears Suspicious
- ☐ Poor Judgement
- ☐ Impaired Judgement
- ☐ Suicidal (Talk/Wishes)

Comments/Clarifications:

MFP Assessment

FUNCTIONAL ASSESSMENT

Activities of Daily Living	Completely Able	Able with Help/Device	Completely Unable	Who Assists?
Bathing				
Dressing/Undressing				
Eating				
Toileting				
Bladder Continence				
Bowel Continence				
Getting In/Out of Bed				
Getting Around Inside				
Stair Climbing				
Wheeling				
Grooming/Hygiene				

Instrumental Activities of Daily Living	Completely Able	Able with a Little Help	Able with a Lot of Help	Completely Unable	Who Assists?
Meal Preparation					
Light Housework					
Laundry					
Shopping					
Taking Medicine					
Getting Around Outside					
Transportation					
Money Management					
Telephone Use					
Care/Supervision of Children					
Life Skills					

MFP Assessment

FUNCTIONAL ASSESSMENT
(*Continues)*

Other*PleaseSpecify;*

Comments:

MFP Assessment

INVENTORY OF COMMUNITY SERVICE AND SUPPORT NEEDS

Housing

1. **Rate Preference For Living Arrangement** (1 = First Choice; 2 = Second Choice etc)

☐A. Alone in your home or apartment ☐B. Live with Family

☐C. Live with friend(s) ☐D. Assisted Living Facility

☐E. Foster Care or Alternate Family Placement ☐F. Other

2. **Desired Location-** (City/County)_____

3. **Accessibility Requirements-** Check All That Apply

☐Widened Doorways	☐No Step Entrance	☐No Stairs
☐Bathroom Handrails	☐Roll-In Shower	☐Automatic Door Opener
☐Environmental Control System	☐Entrance Ramp	☐W/C Access Kitchen
☐1st Floor Apt	☐Curve Cut	☐Other_____

4. **Require Location Within Public Transit Service Area** ☐Yes ☐No
5. **If Living Arrangements Has Been Identified**

☐A. With others Living With:_____
☐B. Independent Residence Desired Location: _____
☐C. Foster Care Contact: _____
☐D. Assisted Living Facility Facility Name: _____
☐Other_____ Desired Location: _____Desired Agency: _____

Address: _____City:_____State:_____ZIP:_____

Contact: _____Phone:(_____) _____-_____

Type of Residence:	☐House	☐Apartment	☐Guest House
Status:	☐Room Available	☐Agreement	☐Would Pay Rent
Roommate:	☐Needed	☐Available	☐Will Share Rent
Condition:	☐Modification	☐Repair/Renovation Needed	

What is the guardian's/family's preference for a living arrangement for the resident?
_____

Assessment Completed by Name& Title:_____
Date Completed: _____
Email Address and Contact Number: _____

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